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THORACIC AND ABDOMINAL ANEURISMS OF THE AORTA.

[Read before the Boston Society for Medical Improvement, and communicated for the Boston Medical and Surgical Journal.]

By J. N. BORLAND, M.D.

THE patient was a sailor, 36 years old, born in Finland. He entered the Boston City Hospital, December 8th, 1865, and reported that two years previously he had general dropsy, and was cured in two months. With the exception of an attack of gonorrhœa eighteen months ago, he continued well until three months before entrance, when he took a severe cold after exposure, and had cold in his head, cough, and pain in cardiac region. These symptoms left him in two weeks, and since then he has had constant pain in his hips, and in the lower part of his back, but never above the crista ilii. Has had no return of the dropsy. Has not been confined to the bed.

General appearance thin and anæmic. Pulse 60, good. Sounds of heart normal. Tongue has a thick brown coat. No appetite or dyspepsia. Bowels are commonly constipated. Urine less in quantity than natural, and high colored; specific gravity 1.020; reaction acid, albuminous, and under the microscope showing epithelial scales and pus corpuscles. Old cicatrices of buboes in groins. No enlargement of glands, nodes or other indications of constitutional affection from syphilis.

He was ordered fluid extract of buchu, and fomentations to vesical region at night, with a pill containing ferri protocarb. gr. iij., pulv. aloës, gr. ss., every four hours, and house diet.

He began soon to pass much of his time in bed, from weakness and pain felt in his abdomen when walking. When in bed and lying on his back this pain was not felt, but it prevented his resting on his side.

On December 11th, without apparent cause, the pain through the pelvis being relieved, he began to vomit watery fluid, and the tendency to this lasted for five days. On the 13th, during the morning visit, he suddenly had a very severe epileptic convulsion, which gradually subsided, with consciousness slowly returning and fully re-

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established in about four hours. This was unaccompanied by any other cerebral symptoms; and he afterwards stated that he was sure he never had previously had any such convulsion, nor was there afterwards any tendency to repetition.

Dec. 17th.—The buchu was stopped.

19th.—No albumen or pus was discovered on examination of the urine.

20th.—Felt pain in vicinity of heart when standing up.

21st.—Pulse 96. Complained of severe pain in left back and side of thorax, especially while standing up. Nothing abnormal was discovered upon a careful physical examination. The iron pill was omitted, and he was ordered a solution containing five grains of iodide of potassium three times daily.

27th.—The patient showed no improvement, the anæmia seemed increasing, and he complained of weakness; his pulse was quick and small, varying from 92 to 104. At times he felt no pain, but at others he complained of pain in his left chest and in his abdomen, but of a vague character, of uncertain duration and intensity, and referable to no fixed spot. His nights were wakeful. I omitted the iodide of potassium and ordered him ten drops of tincture of chloride of iron three times daily, and whiskey half an ounce three times daily.

29th.—Pulse 92, small, weak. Had four hours sleep after morphia. Nothing abnormal could be discovered in sounds of heart or lungs.

Jan. 2d.—He could not sit up without increasing his pain, and walking produced dizziness.

4th.—Pain is only felt in the latter part of the day and at night, and then in the region of the stomach; the abdomen was flat, soft and tympanitic, nothing unusual being detected on exploration. A solution containing five grains of citrate of iron and quinine was substituted for the tincture of the chloride of iron.

5th.—Pulse 72, counted with difficulty. He was ordered frequent supplies of beef-tea.

From this time until Jan. 27th, the patient continued to slowly depreciate in condition, with some days of relief, but always looking anæmic, growing thinner, feeling weak, and with vague pains, sometimes felt in one place, sometimes in another, occasionally vomiting, and never responding to stimulus, various remedies being used, but all equally without benefit.

On the 27th, the record states that the patient vomited on the evening before, was afterwards quiet but wakeful till midnight, then seized with severe and sudden pain, described as shooting from the right hypochondrium to the left ilium, and followed by fainting. To-day, he looks sallow, thin and weak; lips blue. Abdominal pain gone, but soreness remaining. One dejection in night after disturbance. Pulse 96. Great thirst.

Jan. 30th.—Tongue swollen, sore, stiff, covered with a thick, dirty-

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white, moist coat. Lips swollen and aphthous. Some stiffness about palate on swallowing. Examination of urine shows only slight in crease in specific gravity, and the presence of albumen, but no casts.

Feb. 1st.—"Yesterday P.M. the patient was apparently moribund, insensible, pulseless, with cold sweats. This condition was preceded by an access of intense abdominal pain, shooting down the right thigh; he rallied, however, under liberal administration of brandy. Catheter, passed this morning, drew off a small quantity of clear urine. Abdomen full and tympanitic. Pulse 100, steady. Smell of breath and body cadaverous."

At this time he assumed a position on his right side, which he retained until his death. He took no food, except drinking freely of brandy and water. No marked change took place, his pulse retaining its character, small, thready, rapid, 96 to 112, until Feb. 4th, when, reaching after his brandy, he suddenly died.

The impossibility in this case of forming any accurate diagnosis, rendered the autopsy one of marked interest as offering the solution to a difficult problem. I could only recognize the fact that grave disease existed somewhere. The steadily unfavorable progress in spite of nourishing and stimulating treatment, and the non-response to stimulation, showed it plainly. The increasing emaciation; the pale and anxious countenance, with its leaden hue, pinched features and livid lips; the frequent pulse; the varying pains; the occasional nausea and dyspepsia; all suggested to my mind that the disease might be malignant, yet where located or of what organ I could not tell. The healthy-sounding heart and lungs, the non-detection of a tumor of any sort, left me entirely in the dark; and the result proved that a patient may remain for weeks in a hospital, under constant inspection, and be frequently visited by numbers of experienced and skilful physicians, and may finally die of aneurism without the character of the disease being suspected; and also may live even for days after rupture and large effusion of blood, as in this case, where rupture of the abdominal sac took place undoubtedly on the afternoon of January 31, death not occurring till February 4, at 4, A.M.

Autopsy, Feb. 5th, 1866, by Dr. SWAN, Pathologist to the Hospital.

Body stiff from cold; somewhat emaciated; distinctly jaundiced.

The heart was healthy, not large. The pericardium contained upwards of one ounce of serum. No fluid in the pleural cavities; but both lungs were slightly bound, in places, to the wall of the chest by old firm bands of lymph, the left being also firmly attached to the diaphragm. The apices of both lungs contained a few hard tubercles.

There was marked but not excessive atheromatous disease of the aorta for most of its extent. Just beyond the arch, its upper limits about one inch and five eighths from the subclavian, was a rather abrupt and irregular opening about an inch in transverse and rather less in longitudinal diameter, communicating with a somewhat flattened aneurismal cavity, about two inches wide and long, with the walls

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of which the inner arterial coat seemed to some extent continuous. The sac contained coagula, which were broken up by the process of removal, it having been firmly adherent over the left side of the body of a vertebra and over two contiguous ribs. These bony surfaces were rough and carious, without being deeply eroded. At the side of the opening the aorta was dilated into a distinct, narrow, rather shallow pouch an inch and a quarter long, and lined at the bottom with a thin layer of firmly adhering old coagulum.

The position of the abdominal organs was for the most part normal; but the stomach was curved rather sharply and the pyloric end seemed pushed to the left of its usual situation.

About two pints of serum were found in the abdominal cavity; and lying on the upper surfaces of the liver and stomach, and extending over the flexure and in front of the latter organ, were thick sheets of black coagulated blood, recent, but sufficiently firm to be removed entire. The same filled the spaces of the pelvic cavity.

In the right lumbar region was an irregularly roundish mass of recent black coagulum, as it seemed to be, measuring vertically six or seven, and laterally five inches. It was quite firm and consistent, and was in part apparently covered by thin membrane. The cœcum and adjacent portion of colon were rather firmly attached to its anterior and lower surface, and a portion of the coagulum evidently lay between the folds of the meso-cœcum and perhaps of the meso-colon. The right kidney and supra-renal capsule lay deeply enveloped in the mass, and the former, when removed, after section left a smooth mould lined by its capsule. In this mass was a cavity with rather smooth walls lined by firm old dark-red fibrine, admitting three or four fingers to their full length, through an opening in the abdominal aorta, two inches long by one and three quarters wide, just below the cœliac axis, and six and three quarter inches from the mouth of the thoracic aneurism. The inner coat of the artery terminated in part abruptly at the brink of the aneurism; elsewhere seemed gradually lost in the cavity. The particular point whence the hæmorrhage occured was not noticed.

About an inch below the cœliac axis, the superior mesenteric artery, as pointed out by Dr. Jackson, was found cut off close to the aorta, but so completely obliterated or plugged that no trace of its orifice could be found upon the inner surface of the sac. A little less than a quarter of an inch below the level of the superior mesenteric, the right renal artery was traced for an inch and a quarter from a cut surface to a point in the sac nearly two inches from the mouth, where it became completely obliterated. The left renal was not positively recognized.

The right kidney was rather below the normal size, as if from compression. In the cortex were two or three irregular masses of a pale yellowish color, bordered by a bright red line, which proved under the microscope to be very fatty, the tubes being crowded with

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granular pellets corresponding to the original epithelium. Left kidney rather above the normal size. The cortical substance of both showed bright red streaks and spots; but in general the epithelium, though slightly granular and opaque, was normal in other respects.

Liver large, rather fatty. Other organs not remarkable.

SPONTANEOUS DISLOCATION OF THE CRYSTALLINE IN BOTH EYES. SUBSEQUENT SEVERE SYMPTOMS IN ONE EYE REQUIRING THE REMOVAL OF THE DEGENERATED LENS BY OUT-SCOOPING COMBINED WITH IRIDECTOMY.

[Read before the Boston Society for Medical Improvement, and communicated for the Boston Medical and Surgical Journal.]

By Henry W. Williams, M.D.

On the 19th January, 1866, I saw a man of about 40 years of age, who gave the following account of his case. He had always, since his remembrance, had imperfect vision in the left eye, and had at times observed in its anterior chamber what seemed like a drop of olive oil, which would again disappear. From his account of his symptoms there can be no doubt that this was the displaced crystalline. About a year since he began to have pain in and around this eye, with photophobia and lachrymation, accompanied by injection of the vessels of the globe. After some time a cloudy appearance was observed in the field of the pupil, and vision was gradually lost. In the right eye, also, the sight became less perfect, and he was annoyed by double images in this eye, one of them being more clearly defined than the other.

On examination, the left pupil was seen to be greatly distended, and its field was occupied by a dark mass with a ring of yellowish opacity around its margin. So dark was the centre of the pupil that it seemed at a first glance perfectly clear. The anterior chamber was nearly filled, and the cornea pressed upon by this mass, and by its crowding upon the ciliary region, an irritable condition was kept up, which not only disabled him from business, but threatened to induce a sympathetic inflammation of the other eye. The globe was a little harder than the other. He was therefore advised to submit to an operation for the removal of the degenerated lens, which if allowed to remain displaced must continue to be a source of irritation, and, if it should appear to be necessary, to sacrifice even the anterior half of the globe, so as to obtain relief from pain and secure the safety of the other eye.

The right eye showed a dislocation of the crystalline towards the inner canthus, to an extent equal to half its diameter. Slight cloudiness was also beginning in the lens. With much difficulty he could read a large print when brought very near his eye. A narrow crescent of clear space could be seen at the outer margin of the pupil,

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